

The Administrative Feasibility of Using the Tax System for Health Care Reform:  
Comments on Holtzblatt and Hevener and Kerby  
Sherry Glied  
Health Policy and Management  
Columbia University

The papers by Janet Holtzblatt and by Mary Hevener and Chip Kerby are terrifically useful. Policymakers often take implementation issues for granted – as though a wave of the wand could change how large bureaucracies, like the IRS, work and how they interact with the rest of society. These papers are a critical reminder that government agencies, like the individuals and businesses whose behavior we wish to alter through policy, depend on resources, respond to incentives, and have goals of their own. The papers suggest that we should be humble not only about how such agencies implement policies, but also about how much influence these policies can have, in practice, on the structure and performance of the health care system. As Holtzblatt points out, the IRS is an \$11 billion agency and only a minute portion of its tasks involves manipulating the behavior of the \$2 trillion health care system.

### Why the IRS?

Current interest in implementing health care reform through the tax code system stems from a desire to expand and rationalize coverage while relying primarily on the private sector to provide health insurance and health care services. None of the politically tenable options for health care reform would involve building a new public program or greatly expanding an existing program.

This goal and these constraints suggest two possible policy directions. The first is to abandon health insurance as a strategy for expansion of access to care and to rely instead on a substantially enhanced health care safety net. From an administrative perspective, this approach has notable benefits. Safety net providers can treat their patients as they emerge, without a need for any government agency to keep track of who these patients are or how much they have paid. The flaws of this approach are equally apparent. A low-administrative-cost safety net system cannot focus resources on those who most need it; effectively assess the quality of care provided; or reliably account for services provided and related costs. The costs of building and maintaining such a system, in a way that would attract a sufficient number of qualified providers, would be very great.

That leaves direction two – maintain reliance on an insurance framework, based mainly on private coverage, and use an existing government agency to distribute subsidies to those who truly need them. Two government agencies are in regular contact with a large proportion of Americans and collect information on income: the Social Security Administration (SSA) and the IRS.

Many countries operate universal health insurance programs through the equivalent of the SSA. The SSA has regular contact with workers, through their employers. As Holtzblatt points out in studying the analogous situation at the IRS, tax compliance through

employers is generally better than through individual filing. The SSA is in near real time contact with workers, and the timeliness of contact is important in the health insurance context. But the SSA cannot capture non-workers. It has information only on wages, and not on family incomes, and these can be quite different, especially for two earner families. The SSA would not be able to distribute family-income based subsidies. The SSA option would work best with a reform that had an automatic, subsidized default option, with the IRS conducting reconciliation at year end.

### Using the IRS for Health Care Reform

The flaws of the safety net and SSA approaches leave the IRS as the best option available. The IRS has some important strengths as a venue for health reform. For filers, who constitute most of those who would be required to pay for any portion of their health insurance premium, the IRS collects detailed data on family income. The IRS has experience in delivering subsidies to low income families. It has a long history of working with employers and, through these relationships, could potentially develop methods to deliver subsidies in a more timely fashion. Nonetheless, as these papers point out, the IRS has many deficiencies as a vehicle for health care reform.

Both the Holtzblatt and Hevener and Kerby papers point out a host of specific problems with the IRS, but they all arise from the same basic institutional reality. The IRS is an agency designed to process large numbers of tax returns fairly and expeditiously so as to collect revenue for the federal government. That is its principal mission. Policy directives that require the agency to stray from that mission tend to be poorly implemented. The agency's internal and external incentives reward behavior that contributes to its fundamental mission. Hevener and Kerby provide a depressing litany of ambitious health-related policies where the IRS has failed miserably in execution. In some cases, regulations have never been developed. In others, enforcement has been non-existent or inconsistent. Elaborate strategies have been developed to circumvent the intent of the policies and the IRS has not kept pace. The IRS's only real success in health policy has been the tax treatment of ESI (s. 106) – a policy which required the IRS to do --- nothing.

The IRS is not a natural place to conduct health care policy – but it is where policy will be conducted, for lack of an appealing alternative. Under an individual mandate style proposal, the IRS might be used as a venue to assess and deliver subsidies, to assess and collect penalties, and to monitor coverage. Under a proposal to eliminate the tax exclusion and substitute a tax credit, the IRS might be required to assess employer payments for health insurance so that these can be counted as taxable income, and deliver tax credits for health insurance purchased by individuals. Whatever reform strategy is selected, the IRS will be working to force economic agents to behave in ways that are against their self-interest.

As these papers illustrate, the IRS's capacity to alter behavior related to the health care system is limited. The complexities of health care and health insurance add another, and quite distinct, dimension to data collection and payment enforcement, one that is outside the IRS's institutional competence in assessing income flows. To be effective, reform

efforts, whatever direction they take, will need to take account of these limitations. Successful reforms will need to assign responsibilities to government agencies, and other institutions, according to these agency's existing competencies. Beyond design, policymakers will need to provide, both at the initiation of reform and in subsequent years, the resources and direction to allow agencies to execute their roles. The public administrative costs of effective health care reform, whichever agency runs it and whatever direction it takes, are likely to be substantial and ongoing. Failure to acknowledge and budget for these costs is a prescription for failure of reform itself.